MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address RS Medical P O Box 872650 Vancouver, Washington 98687-2650	MDR Tracking No.: M4-03-8195-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TASB Risk Management Fund Box 12	Date of Injury: Employer's Name: Insurance Carrier's No.: 0250011011789643

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/16/03	02/15/03	E1399	$215.00	$215.00

PART III: REQUESTOR'S POSITION SUMMARY

"Payment has been denied stating charges will exceed $500.00 based on the previous month's rental charges for the device and therefore require preauthorization. However, the previous month's rental charge for this device was $250.00. Since the denied charge is also $250.00 charges do not exceed $500.00."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely. Denial listed on the EOB state, "Preauthorization not obtained. All durable equipment in excess of $500.00 PER ITEM requires preauthorization."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider submitted information indicating that they had not exceeded the $500.00 limit that is required for preauthorization for the charges listed per rule 134.600 (h).

Therefore, based on the information provided reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

				Total Left Column:			$0.00
				Total Amount Due:			$215.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of **$215.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

	Michael Bucklin	01/11/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____